Front Lines

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THIS ISSUE

The Front Lines of a Long Twilight Struggle for Freedom

— John F. Kennedy

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News & Features


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Cover: Noah Hendler's photos capture the strength and weariness of the grandmothers struggling to care for the children of Mpondas, Malawi, as the HIV/AIDS pandemic strikes down parents, destroys the economy and undermines the traditional culture.

Photo credits: Cover, Noah Hendler; page 1, USAID/Uganda; pages 2-3, AIDSCAP/Family Health International; page 4, WHO/ J. Hernandez Claire; pages 5-7, Noah Hendler; page 8, PSI; page 10, WHO/H. Anenden; page 11, Philip Birmingham Photography.

HIV/AIDS undoing decades of development

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By J. Brady Anderson

AIDS is leading cause of death in Africa

Staggering as it is to contemplate, more than 50 million people have been infected with the human immunodeficiency virus (HIV) worldwide. In 1999 alone, 2.6 million people died, and 33.6 million are now living with HIV/AIDS.

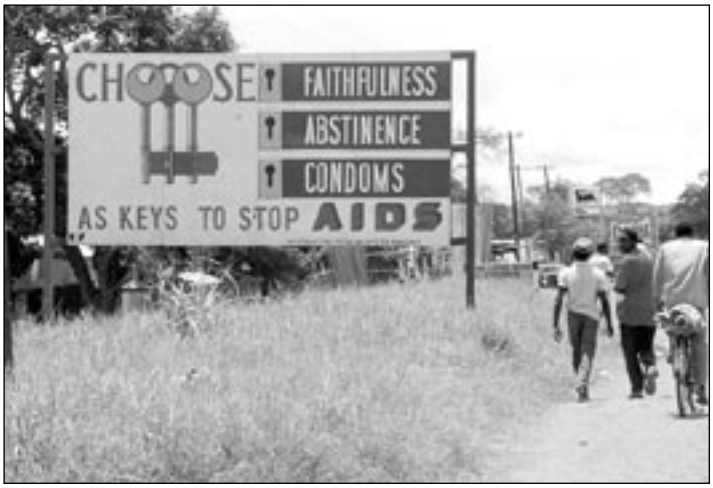
To grasp the true dimensions of this tragedy, imagine a scenario in which every child and adult in New York City, Los Angeles, Chicago, Houston, and in the 46 next largest cities in the United States were either dead or infected with a deadly condition for which no cure or vaccine existed. Such a catastrophe would still fall short of what is happening in the AIDS pandemic — by almost 8 million people.

AIDS destroys the human immune system, making its victims vulnerable to deadly opportunistic infections like tuberculosis. It is now the leading cause of death in Africa — and the fourth leading cause worldwide. Africa is the hardest-hit continent in the world by far — 60 percent of all men living with HIV, 80 percent of all women living with HIV, and 90 percent of all children living with HIV are in Africa.

The disease has gained a foothold in Africa for several reasons. Population movements due to conflict, natural disasters, and migrations across borders or from rural to urban areas for employment, all have contributed to the increase of HIV/AIDS infection. In addition, as HIV spreads to the general population, infections among women of child-bearing age have increased, along with the threat of passing the infection to their newborns and nursing infants.

The spread of HIV/AIDS on the continent is having major adverse effects on current health infrastructures and society as a whole. Life expectancy has plummeted, and infant and child mortality rates are doubling and tripling in some countries. Children who were among the first generation to have access to schooling have had to drop out to earn a living and care for dying parents. Millions of AIDS orphans will lack food, health care and nurture as families, villages and societal systems are overwhelmed. Many will become child laborers or suffer sexual exploitation, without the education and skills to improve their lot as adults.

Four decades of development progress are being undone by AIDS, which has become the single greatest threat to the continent's future economic development. Many African countries are beginning to experience declines in life expectancy, child survival and productivity as a result of HIV/AIDS.



Billboards placed along Uganda's roads were part of the campaign that helped reduce the rate of increase in HIV infections in urban areas from 27 percent to 15 percent.

Four decades of development progress are being undone by AIDS. . . .

Tragedy touching everyone in Africa

The harsh statistics cannot fully convey the human tragedy of AIDS in countries struggling to provide the most basic health care. AIDS touched our own lives when my wife, Betty, and I were in living in Africa. A very valuable, loyal and capable staff member and friend who worked at the ambassador's residence in Dar es Salaam died of AIDS while we were there, leaving a wife and three children.

That family's tragedy is sadly familiar to families all over Africa. AIDS has touched the lives of almost everyone on the continent, taking the lives of young men and women, in particular, when they are most likely to have young children — and before they have had a chance to fulfill their promise and their dreams. They are struck down during their most productive years, and the hard-won education and skills that might have benefited their countries in such important ways are lost with them.

U.S. largest donor worldwide in the fight against HIV/AIDS

The U.S. government is the largest donor in the fight against AIDS globally and is recognized as a leader in technical expertise. For over a decade, USAID has been a leader in the fight against the AIDS pandemic, assisting 46 developing countries — 22 in Africa. As the disease has spread over the past 10 years, USAID has responded by providing over $1.2 billion in assistance, approximately 60 percent to sub-Saharan Africa.

For the past seven years, USAID's annual budget for AIDS has remained at about $123 million. However, in FY 2000, President Clinton's LIFE Initiative [see article, page 2] plus additional increases from Congress raised our budget for HIV/AIDS from $125 million to $200 million. About $130 million is directed to Africa.

Current programs reach less than 10 percent

With the FY 2001 increases in HIV/AIDS funding President Clinton has requested, we will be able to scale up activities in prevention and care of patients, help orphans and vulnerable children and reduce mother-to-child transmission in 20 high-emphasis

countries. This additional funding will enable USAID to expand these programs beyond the 10 percent of vulnerable persons who are presently covered.

Finally, USAID aims to help build critical health and educational infrastructure in these countries so that African and Asian institutions and community organizations can better take the lead in responding to the epidemic in their countries. This is a time of special opportunity when we can galvanize all kinds of groups to work with governments all over the world to accelerate the fight against HIV/AIDS.

Africa is the hardest-hit continent in the world by far . . . .

Over the next five years, USAID will seek to significantly decrease the incidence of HIV in target groups — including children and young people 15- to 24-years-old — and increase support to households caring for children and others affected by AIDS. We will work closely with the United Nations, other bilateral donors and the governments of affected countries to achieve that vital goal.

Models for success: Uganda and Senegal

Models for success already exist. With USAID support, Uganda reduced the prevalence of HIV in urban areas from 27 percent to 15 percent during the last decade — reversing the growth of the epidemic. Senegal was able to hold its HIV prevalence rate to less than 2 percent, even as rates in surrounding countries continued to escalate. The Uganda and Senegal models prove that the battle can be won — and challenge us to achieve comparable success in other countries in the developing world that are struggling to combat AIDS. ■

By David Stanton

LIFE Initiative: a significant turning point in U.S. government's global fight against AIDS

President Clinton's LIFE Initiative (Leadership and Investment in Fighting an Epidemic, marks a significant change in the U.S. government's — and USAID's — approach to the global fight against HIV/AIDS, which previously concentrated on prevention and research.

The LIFE Initiative will support USAID's longstanding prevention efforts while expanding activities aimed at providing care to persons with HIV infection. Congress provided $100 million in the FY 2000 budget to fund the initiative at President Clinton's request, of which USAID received $55 million.

One of the most successful AIDS care organizations in Africa has been supported through a partnership with USAID. The AIDS Support Organization (TASO) is a non-governmental organization in Uganda, providing services including counseling, basic medical care and family planning services, as well as food supplements, skills training, support programs and assistance to AIDS orphans. Under the LIFE Initiative care and treatment services will be provided to HIV-infected persons in 13 targeted countries — India and the 12 most severely affected countries in sub-Saharan Africa.

Much can be done to improve the quality and duration of life for people living with HIV/AIDS and their families.

A counselor teaches young Thai women about HIV/AIDS prevention in the factory where they work. Reaching people in workplaces, schools, and religious and community meeting places helps Thailand reduce new HIV infections.

The LIFE Initiative also seeks to reduce by 25 percent the current rate of 5.8 million new HIV infections each year in the 13 target countries. Programs in target countries will be complemented by regional activities in western and southern African countries, which have the highest number of new infections, the potential for greatest impact and active U.S. government presence.

USAID will take the lead in implementing the initiative, collaborating with the Department of Health and Human Services and

the Department of Defense. Interventions will be grounded in goals and objectives consistent with those established by the international community in collaboration with the Joint United Nations Program on AIDS (UNAIDS).

The initiative addresses four key elements critical to fighting the AIDS pandemic:

Primary prevention

Prevention activities are aimed at slowing — and ultimately reversing — rising HIV rates in developing countries, where 90 percent of new infections are known to result from either sexual transmission (80 percent) or mother-to-child transmission (10 percent). Another 5 percent result from contaminated blood transfusions and infected needles. Activities include voluntary counseling and HIV testing, prevention of mother-to-child transmission, treatment of other sexually transmitted diseases, social marketing of barrier methods to prevent transmission, behavior change interventions, and blood safety, targeting both civilian and military populations.

Taking HIV prevention information to the people at risk, this counselor talks to truck drivers in Tanzania.

Improving community and home-based care and treatment

Currently in sub-Saharan Africa and India, care and treatment for HIV-infected persons and support to their families are minimal. Less than 5 percent of people in these countries know their HIV status, and health care providers lack resources to diagnose and treat HIV and the associated opportunistic infections. Under these conditions, use of the expensive "state-of-the-art" anti-retroviral treatment regimens that require careful monitoring is a long way off. But even in the absence of anti-retroviral drugs, much can be done to improve the quality and duration of life for people living with HIV/AIDS and their families.

The leading killer of AIDS patients in the developing world is tuberculosis (TB). Using directly observed therapy regimens (DOTS), TB can be cured in HIV-infected persons, increasing both the quality and duration of a person's life. Ideally, inpatient care would be complemented by community outpatient treatment, combined with psychosocial support services utilizing a wide range of community workers, including traditional healers. The LIFE Initiative will support basic medical, home and community-based care to greatly expand the availability of these services.

The LIFE Initiative will support USAID's long-standing prevention efforts while expanding activities aimed at providing care to persons with HIV infection.

Activities to assist children affected by AIDS

Before the end of this year, nearly 24 million children are expected to have lost one or both parents in 19 of the African countries where the HIV/AIDS epidemic is full-blown. By the end of the next decade, this number is expected to increase to more than 40 million children. Despite the magnitude of this crisis, services in developing countries for children orphaned by AIDS are extremely limited or non-existent. The LIFE Initiative will support USAID in undertaking activities to assist children affected by AIDS and their families, primarily through Title II, Food for Peace programs.

Strengthening the capacity of target countries to fight HIV/AIDS

Within the target countries, greater political commitment is critical. The LIFE Initiative will emphasize developing the capacities of governments, the private sector, non-governmental organizations and research institutions to implement effective interventions. The initiative will not support all elements in every country, but tailor programs to each country's needs and seek to complement existing efforts. UNAIDS estimates that more than $1 billion per year is currently needed for prevention of HIV/AIDS in sub-Saharan Africa alone. The LIFE Initiative will contribute significantly toward this goal, as well as to the global partnership necessary to bring effective programs to adequate scale. U.S. partners involved in LIFE will collaborate with UNAIDS and other international and local agencies to leverage additional host country, multilateral, bilateral, and private resources. ■

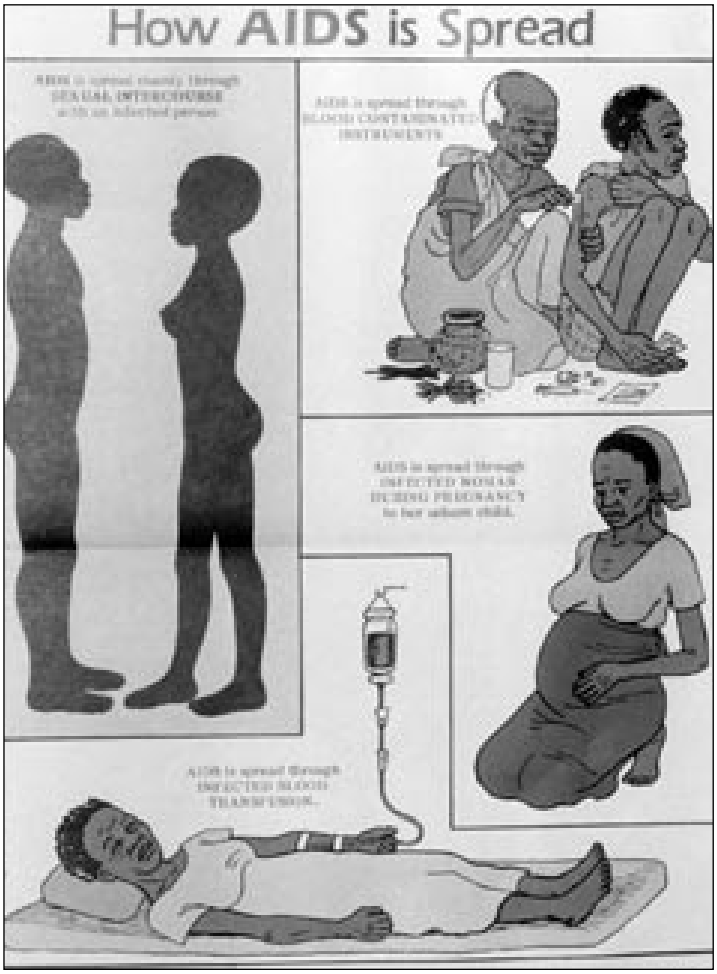
— **Stanton** is an epidemiologist in the Global Bureau's Public Health and Nutrition Division.

By Naomi Rutenberg, Ph.D.

Preventing HIV transmission from mother to child

Nine out of 10 HIV-infected babies are born in Africa. This is due to high fertility rates combined with high HIV infection rates. In some urban centers in Southern Africa, it is not uncommon to find HIV infection rates as high as 20 percent to 30 percent among pregnant women tested anonymously in antenatal clinics (serving newborns and their mothers). AIDS has already doubled infant mortality in the most severely affected countries and threatens to reverse years of progress in child survival.

A groundbreaking, multisite study of services aimed at preventing the transmission of the HIV/AIDS virus from mother to child is being conducted in Kenya and Zambia by the Horizons Project (implemented by the Population Council and five other organizations, funded under a five-year cooperative agreement with USAID). The study assesses the acceptability, operational concerns, cost and impact on mother-to-child HIV transmission, child morbidity and mortality of a package of services offered in antenatal clinics.



Preventing transmission of the HIV/AIDS virus from mother to child is critical in Africa, where nine out of 10 babies with the virus are born.

AIDS has already doubled infant mortality in the most severely affected countries and threatens to reverse years of progress in child survival.

This research is examining several interventions, including voluntary HIV counseling and testing and provision of anti-retroviral drugs and breast milk substitutes to HIV-infected mothers. The study is a major component of an international effort led by UNICEF and the United Nations Program on HIV/AIDS (UNAIDS) to produce critically needed information for making informed choices and developing best practices for the prevention of mother-to-child transmission.

Milestones to date include development of a research protocol in collaboration with local partners, needs assessments in clinics and communities as well as development of a monitoring and evaluation plan measuring utilization of services and impact. The first report on the study will be issued by the end of this year.

In Kenya, Horizons is collaborating with the Network of AIDS Researchers in East and Southern Africa (NARESA), which will implement the study in cooperation with the Ministry of Health, UNICEF/Kenya and the World Health Organization. In Zambia, Horizons is collaborating with the Mother-to-Child-Transmission Working Group, appointed by the Central Board of Health. The package of services, including equipment, supplies and educational materials, will soon be available at sites in both countries.

Working with these partners, Horizons has also developed a training curriculum, which, for the first time, addresses the roles of clinics and communities in preventing mother-to-child transmission. The curriculum targets health workers and supervisors, community leaders, people-living-with-HIV/AIDS groups and government program managers. The course covers a wide spectrum of mother-to-child transmission concerns including prevention, integration of transmission interventions in maternal and child health settings, counseling and community mobilization, and assistance to HIV-infected mothers in making choices about safe ways to feed their infants.

Because of the critical need for this type of training, the project has received numerous requests for the curriculum from institutions throughout sub-Saharan Africa. So far, staff have been trained in the new curriculum at three pilot sites in Kenya and six pilot sites in Zambia. ■

—**Dr. Rutenberg** is research director of the Horizons Project.

The grandmothers of Mpondas

Malawi's vice president: AIDS is taking away our future

On March 24, Vice President Justin Malewezi of Malawi appealed to donor countries for additional help in fighting HIV/AIDS. "Our war chest against AIDS is empty. We are a nation in grief as AIDS is devastating our economy and the fabric of our society," he said, adding that AIDS is "taking away our future."

AIDS has left thousands of orphans, he said, and caused increased poverty in a country where 60 percent of the people were already living below the poverty line set by the U.N. Development Program.

Health and Population Minister Aleke Banda said AIDS has reached crisis proportions in Malawi. The official death toll is over 265,000, and 14 percent of Malawi's 11 million people are living with the HIV virus, with the adult infection rate at 26 percent in urban areas.

In the 23 countries included in USAID's 1997 study, "Children on the Brink," the number of children who will lose one or both parents as a result of the HIV/AIDS pandemic will reach 24.7 million this year and increase to over 41 million in the year 2010. Most of the countries in that study are in Africa, where the epidemic began early and is now severe. In all 23 countries studied, AIDS-related mortality is expected to eliminate the gains made in child survival over the past 20 years.

USAID's Displaced Children and Orphans Fund develops and supports programs that strengthen the capacity of families and communities to provide care, protection and support for displaced children and orphans. The fund supports Save the Children's COPE Program in Malawi, which has become a model for community-based support and protection programs for vulnerable children, especially children orphaned or otherwise affected by HIV/AIDS.

In Malawi, where the economy is being devastated by HIV/AIDS, grandmothers struggle to care for the children.

Writer Craig Cohen and photographer Noah Hendler visited the cluster of villages in Mpondas, Malawi, in 1997 to document the social ramifications of HIV-AIDS in a project co-funded by Save the Children's COPE Program and Duke University's Hart Fellows Program. The Hart Fellows Program places recent college graduates in one-year fellowships with international humanitarian organizations. Cohen and Hendler worked with translator Daud Maulidi to interview and photograph government officials, hospital workers, traditional authorities and community members affected by the disease. Much of their work focused on grandmothers caring for orphans, one of the most vulnerable and visible populations affected by the virus.

The National AIDS Control Program estimated earlier that this year 300,000 of Malawi's children will have lost one or both parents — more than twice the number in 1995. During their initial visit to Mpondas and in their subsequent visits, Cohen and Hendler have found that grandmothers are often unable to find work to provide for their orphaned grandchildren, many of whom lack the money to pay for their clothes or school fees. In addition, children and adolescents often have the increased responsibility of caring for their younger siblings and their grandparents.

The stories of the people whose words and pictures appear here illuminate the tragedy that has befallen the children and grandmothers of Mpondas. The following are excerpts from a book that Cohen and Hendler are currently working on about the life of one African community in a time of AIDS. The tragedy that has befallen Mpondas is now spreading to other areas of Africa as well, and will strike far greater numbers of people in South Asia and Southeast Asia in the decades to come.

Note: Cohen and Hendler did not ask the people in these photographs if they were HIV-positive, and it should not be assumed that any of them are HIV-positive or have AIDS. ■

The grandmothers of Mpondas: AIDS is a story for the whole community

"There are some things which should be talked about and some things which shouldn't. There are different types of stories for families, stories for governments, stories which involve one individual, and stories which involve the whole community. AIDS is a story for the whole community."
—Emily Chipeta, headwoman of Chipeta village. Her father and grandfather were the traditional leaders of her village.

This traditional healer carries herbs and a bundle of sticks (center front of picture) to use in treating patients, but has no medicine that can cure HIV/AIDS.

"I'm afraid of becoming sick more than I'm afraid of anything else. My grandmother has never talked to me about AIDS. I've just heard about it. I'm afraid of AIDS.

"At first I was afraid of the hippos, but now I'm not afraid. The hippos are the main problem of living here. Sometimes we doze off and while we're sleeping, the hippos come and eat our crops. We throw stones and bang pots and don't sleep most of the night to make sure they stay away. We can't be afraid of the hippos — if we were, we'd have nothing to eat.

"Most of the time, Grandma sits alone by the fire while my brothers and sisters and I sleep. Grandma isn't afraid of the hippos....The worst is when a hippo has a baby to protect — then it's terrible because it thinks you want to take its child. I don't think my grandmother is afraid of anything."
— Shaibu Msosa, 11, grandson of Margaret Zaizi.

—Margaret Zaizi says of the seven grandchildren she cares for,

"Shaibu's father died three years ago from coughing, and I've been taking care of Shaibu and his brothers and sisters ever since. We moved across the river to this garden because in the village there is nothing to eat. Their mother stayed behind to take care of the house." The children see their mother every few days and the grandmother returns to the

"Death used to mean an old person. Now it means someone 14 to 35 years old."

Mr. Maluwa, one of 10 AIDS counselors working at Mangochi District Hospital:

"I'm a counselor, I'm not there to judge. I just listen to what the patient knows about AIDS, and if it's not enough information, then I educate him. The aim of counseling is for the patient to know about the disease so he will change his behavior and for him to stay positive with his problem. It's a very difficult thing when a patient is first diagnosed as being HIV-positive. I sit next to him, try to create a friendly environment, hold his hand. At first, denial is often there and it seems a patient will never accept his problem. He will say, 'My uncle has bewitched me,' or claim that it's just TB. Many who are terminally ill return home and don't say what they have, even to their husbands or wives." With the consent of the patient, he tries to arrange for home-based care that involves the spouse and the village headman.

Domonic Misomali, district social welfare officer in Mangochi, five miles from Mpondas:

"We've had orphans ever since God has created people. As a consequence of AIDS, though, a lot of old people, particularly grandmothers, are becoming responsible for orphans to a much greater extent than in the past. Some refuse to care, but most say, 'What else can I do?' They're not as capable, and, as a result, we're losing a lot of kids.

"Death used to mean an old person. Now it means someone 14 to 35 years old. It's different because young people are dying, the really productive members. We're losing the people who could be assisting in the development of our country. The graveyard is changing, too. It used to be a bushy-type of place, overgrown, not as open. Now, with a funeral almost every day....

"People know about AIDS. Even if you go to the most remote village, they will know information about AIDS. Yet even now you could go to a funeral of a person who has had full-blown AIDS and people will deny it. People know this disease is different from others, and I think we will get to the point that we'll admit people are dying of AIDS. But that is in the long term, it is for the young people. It is a long way before the community as a whole gets there. This reluctance to talk about AIDS makes it more widespread. People aren't getting the true information about AIDS. If people don't know, they won't take any precautions."

Mr. Maluwa believes the silence hampers efforts at AIDS care but says, "People now understand there is a problem because there are so many orphans in the villages. The community knows about this problem, and because of it, some of our cultural beliefs are changing."

village often — mostly for funerals. "It's important to go so that people will mourn you when you die....Some weeks, I go to funerals five days in a row.

"The only time I sleep is during the day for a few hours, so I'm always tired. I bang pots the whole night to keep the hippos away."

"My grandmother is the head of our household, but if she's away, then I'm the head. She goes away a lot — mostly for funeral ceremonies in the village. I take care of my brothers and sisters when my grandmother isn't here. I'm stronger than other children because I'm a child and I'm also an adult."

— Silenga Martin, 11 years old, cared for by her grandmother, Patuma Liwande.

"Every week we have four or five funerals. In the past, people weren't dying like this and grandmothers didn't have to work so hard. When my daughter died, I was forced to become strong. There was no one else to take care of her child. So many people are dying in our community, we remain poor."

— Ndulaga Sampson, grandmother caring for six orphans in Mpondas.

— Emma M'bwana has cared for her eight grandchildren since her daughters died from "general body pains and leg swelling." She says,

"When my two daughters became sick, each of their husbands left them for me to take care of and never came back. Their husbands weren't from Mpondas — like many men here, they were just doing business, buying and selling fish. They said they would come back to help, so I was surprised when they didn't. Now, I never think of them."

Her son helped her when her daughters were sick. "I never asked him for assistance — he did it on his own. Even now he supports me sometimes if I'm having troubles. You know, people have different hearts. Some people have good hearts, some people have bad hearts. My husband had a good heart....I think my son has a good heart. I can't judge all men badly. For my grandchildren, I teach them to have good hearts."

M'bwana builds houses to support her grandchildren. Her sister from Zimbabwe taught her how, digging out the foundation, mixing soil with water and molding the mud into the foundation and building up the walls. When the mud dries, she smooths the walls with water by hand, which takes all day for the inside and another day to do the outside. She has to hire men to put bamboo and grass on the roof. "A big house might take me three weeks, but a small house could take under a week. If it doesn't leak, you could live there your whole life. I don't like building houses, but because of the problems I'm in now with my grandchildren, with no support from their fathers, I need the money."

She built her own house and says, "I'll teach my grandchildren when they grow older. I'll teach anyone who's willing to learn. It's so much more difficult to raise grandchildren than to raise children, especially because my husband is no longer alive to earn money. I had never thought that when I became old I would have to work this hard."

— Rosa Adams, 36, helps her mother, Mbesyaga Bula, care for the 12 children of her two dead sisters.

"We remain poor because everything here is done by ladies — we have no husbands, no fathers. In our community, a man has special responsibilities, like providing food for the family. We've had to do both men's and women's work."

—When Atima Lunde's sister and her sister's husband died, she adopted her sister's three children and her own husband fled, not wanting the additional responsibility.

"I told my husband I couldn't leave my sister's children to die and he didn't understand this." She has been the sole support of her own three children as well as her sister's three and she says she is not looking to remarry. "I'm capable of doing men's work. I built this fence, I work these fields. When my husband returned, I told him to go away. I no longer trust in men, only in my children."

— Manesi John has been caring for her daughter's three children since her daughter died.

"According to our culture, yes, I am supposed to care for these children. But her husband has never sent assistance and has never even come to visit his children. This is not our culture. This depends on the father's heart. Men didn't used to behave like this."

—Kaesim Chipakas is a traditional healer.

"Mostly, I treat people who have been bewitched. I hammer bundles of small sticks and herbs into the corners of my patients' homes. To protect my patients, I put medicine into their blood by making small cuts with a razor blade. I always use different razor blades for each person. I have heard about AIDS— that there is no medication for it, and I believe that. I have tried to treat people with AIDS, but they didn't get cured. Patients never tell me they have AIDS. I know only if I give them treatment and it doesn't work....I can treat a bewitched person, but not someone with AIDS. I tell patients to look for healers who can cure the disease, even though I don't know any....I have fear to the future, whether AIDS will ever have a medication, because many people are dying." ■

"I'm afraid of becoming sick more than I'm afraid of anything else."

In the villages of Mpondas, in southeastern Malawi, there are funerals almost every day.

By John Loftin and Janet Shulman

Revival of AIDS prevention activities in Democratic Republic of the Congo

USAID's mission to Zaire was supporting the largest HIV/AIDS prevention project in Africa when civil unrest forced the suspension of all projects and evacuation of USAID personnel in September 1991. Ultimately, the mission itself was closed and did not reopen until 1997, after Zaire's name had been changed to the Democratic Republic of the Congo (DRC).

Upon its departure, USAID allocated an additional quantity of condoms to the project contractor, Population Services International (PSI) and, in collaboration with its local non-governmental organization, the Association de Santé Familiale (ASF), PSI carried on reduced activities, relying on its own funds and limited assistance from local sources. This situation continued until August 1998, when USAID renewed funding to PSI for the original project.

Intervention to prevent HIV/AIDS is vital to the future well-being of the entire population. Surveys completed by the project in 1999 found that half the young people are sexually active by age 17 and 30 percent of these report having two or more partners. More than 60 percent of the young people reported they never use condoms.

The project, now called AIDSMark, targets vulnerable youth, commercial sex workers and people living with HIV/AIDS, using a multifaceted approach to behavior modification that includes peer education, mass-media information dissemination and social marketing of PRUDENCE brand condoms. A peer education program targets commercial sex workers in Kinshasa. It attempts to reach their clients as well, but that is proving more difficult. Through mass-media broadcasts of care and treatment messages, the project also seeks to change the overwhelmingly negative view of people living with HIV/AIDS and erroneous information about HIV/AIDS. The surveys indicated that over 60 percent of the people living in Kinshasa believe HIV/AIDS can be propagated by witchcraft.

HIV/AIDS awareness activities are being implemented through a collaborative effort by partner non-governmental organizations and community-based organizations, such as churches, the network of people living with HIV/AIDS and neighborhood youth groups, all in cooperation with the Congo's National HIV/AIDS Prevention Program.

All activities are monitored for impact and degree of behavior modification. It was envisioned that 8 million PRUDENCE condoms would be marketed to the general population during the first two years of the project. After only twelve months, 9 million condoms have been distributed.

Street theater, such as this in India, is proving useful in getting the message out about HIV/AIDS prevention and testing. Strategies USAID helped develop in then-Zaire became models for the global prevention effort. Music, drama and quiz shows are part of USAID's prevention efforts since returning to the now Democratic Republic of the Congo in 1998.

Music, theater, quiz shows

The September 1999 African AIDS Conference in Lusaka focused on the decreasing age of those newly infected with the HIV/AIDS virus and the need to devise viable strategies to reach the vulnerable age group of youth between 15 and 25 years old. ASF uses music, theater, quiz shows and witnessing by people living with HIV/AIDS to propagate messages on sexual responsibility dealing with abstinence, fidelity and condoms, focusing on secondary schools and neighborhood out-of-school youth discussion groups. Up to 200,000 students are currently participating in the high school program, which organizes monthly activities in each school produced by a student committee and led by ASF-trained peer educators. The Coffee Club program reaches 42,000 youth who have dropped out of school for economic reasons.

The project's Knowledge, Attitudes and Practices Survey and the Consumer Intercept Survey indicate that a vast majority of people in Kinshasa have heard project messages on radio and television. These results indicate that continued support of this program is helping to make the general population aware of its sexual responsibilities and is giving hope to an entire generation whose future is in doubt. ■

— **Schulman** is program officer at USAID's mission to the Democratic Republic of the Congo. **Loftin** is PSI's representative in the DRC.

By Drs. Gloria Sangiwa, Buhle Ncube and Kerry Richter

New hope in Zimbabwe with voluntary counseling and testing for HIV/AIDS

Zimbabwe has the highest HIV prevalence of any country in the world. Every week in 1998, an estimated 2,000 adults were infected with the AIDS virus and about 1,200 people, including children, died from AIDS-related causes. An alarming 25 percent of sexually active adults in Zimbabwe are HIV-positive.

In an effort to respond to this dire situation, an innovative and urgently needed social marketing program, the New Start Voluntary HIV Counseling and Testing Network, aims to motivate healthier sexual behavior and prevent the spread of AIDS. This national, voluntary HIV counseling and testing network was launched in the spring of 1999 through collaborative efforts of the Zimbabwean Ministry of Health and Child Welfare's National AIDS Coordination Program, Population Services International (PSI) and USAID/Zimbabwe.

The New Start program is an effective, cost-efficient variation of successful HIV counseling and testing programs conducted on a limited scale in several countries. Focusing on the individual, the program encourages customized risk-reduction strategies to motivate behavior change.

Research has shown that people who test negative for HIV are more likely to change their behavior to maintain that negative status when effective counseling is coupled to test results. Those who receive counseling when they test positive are more likely to be motivated to protect themselves and others from HIV and to seek medical attention for early symptoms of AIDS-related illnesses.

Offered at affordable prices, New Start services are targeted to specific groups, including young couples, adolescents, commercial sex workers, transport industry workers and other "mobile" populations. The network integrates voluntary counseling and testing services into existing health service delivery institutions, such as public clinics and hospitals, non-governmental organizations and private health facilities. Establishing the centers at institutions that already provide health-related services helps reduce the stigma of seeking an HIV test.

Zimbabwe has the highest HIV prevalence of any country in the world.

Counseling sessions covering risk reduction are tailored to each individual. New Start staff are trained in standard protocols and procedures to provide on-site, state-of-the-art rapid HIV testing and confidential counseling both before and after testing. When appropriate, referrals are made to community support groups.

The New Start project is funded through AIDSMark, USAID's five-year program being implemented by PSI that uses social marketing to combat the spread of HIV/AIDS and other sexually transmitted infections in developing countries. USAID's mission in Zimbabwe and the National AIDS Coordination Program collaborate closely with PSI in planning, implementing and managing New Start. Project activities are enhanced by the efforts of AIDSMark partner Family Health International (FHI), which assists in project evaluation and provides technical expertise on counseling and procedures.

Social marketing, the promotion and distribution of needed health products and services to lower-income people through local commercial and non-governmental organization infrastructures, strengthens the voluntary counseling and testing model and results in a dynamic program that works to destigmatize HIV testing and encourages people to communicate about HIV/AIDS. Strategic marketing of counseling and testing services is key to promoting New Start. Messages on radio and television and print mass-media advertising are based on consumer research that pinpoints motivations for and barriers to the use of counseling and testing services. New Start also spreads the word about voluntary counseling and testing services and the benefits of knowing one's HIV status through a strategy that includes drama groups in each community hosting a New Start center. Communications campaigns focus on motivating sustained behavior change. ■

Post-test Club in Uganda performs to encourage others to get HIV testing and counseling, which is slowing the spread of infection there. Voluntary testing and counseling are giving new hope in Zimbabwe, as well.

— **Dr. Richter** is deputy director of research for Population Services International, Washington; **Dr. Ncube** is project manager, AIDSMark; **Dr. Sangiwa** is technical adviser, AIDSMark.

By Dr. Connie Davis

Deadly alliance – TB and HIV/AIDS in Africa

Tuberculosis (TB) and HIV/AIDS have forged a deadly alliance in Africa that is fueling epidemics of both diseases and creating a host of obstacles to TB control programs throughout the continent.

Real progress in controlling TB and HIV can be made only through a dual strategy that targets both epidemics.

The Joint United Nations Program on HIV/AIDS (UNAIDS) and the World Health Program (WHO) estimate that 23.3 million Africans are infected with HIV or have full-blown AIDS. Africa has the highest per capita incidence of TB in the world — 259 cases per 100,000 persons — and TB is the most common opportunistic infection associated with AIDS on the continent.

Because HIV suppresses the immune system, people who carry the TB microbe and are infected with HIV are 30 to 50 times more likely to develop active tuberculosis than TB carriers who are free of HIV. Since TB is transmitted through the air, adequate and complete treatment of infectious cases is the best means of prevention. However, TB programs in developing countries that were beginning to control their TB rates are now being inundated by new cases of TB — fueled by the AIDS epidemic.

Eighty percent of the TB cases in the world are concentrated in just 22 countries, and eight of those countries are in Africa: Nigeria, South Africa, Ethiopia, the Democratic Republic of the Congo, Tanzania, Kenya, Uganda and Zimbabwe. Many other African countries have very high incidences of TB rates.

TB is the leading killer of AIDS patients in the developing world and is spreading worldwide at an alarming rate. Although there is still no cure for AIDS, there are treatment advances that can improve the quality and duration of life. TB can be cured in HIV-infected persons by using one of those advances, Directly Observed Treatment Short Course (DOTS) regimens. The DOTS regimens have proven their ability to work, even in resource-poor African countries. DOTS involves giving the standardized anti-TB drugs and observing that the patient takes them daily or three times a week (depending on the type of case and regimen). Despite these encouraging results, only 15 out of 47 African countries have fully implemented the DOTS strategy. Research also indicates that another treatment advance, preventative isoniazid treatment, administered over a six-month period can stop latent TB from developing into the active form in people with HIV/AIDS.

TB can be cured in HIV-infected persons, improving the quality and duration of life. Voluntary testing and counseling are key elements in fighting the epidemics of TB and HIV/AIDS in Africa.

Community-based care project

People infected with HIV or who have full-blown AIDS need services close by. The international health community has developed projects to assess the feasibility, acceptability and cost-effectiveness of community-based TB care. USAID, UNAIDS, the International Union Against Tuberculosis and Lung Disease, the Royal Netherlands Tuberculosis Association and the federal Centers for Disease Control and Prevention in Atlanta are collaborating with the World Health Organization on a project that offers treatment supervision within the community as an alternative to the standard treatment supervision provided by regular health facilities.

The project has eight components in five countries (Botswana, Kenya, Malawi, South Africa, Uganda and Zambia) testing different community mechanisms to deliver TB care. These include using community health workers, traditional healers and "guardians" — designated people who take responsibility in the community and are trained to administer the medication. TB treatment delivered by community workers consistently shows higher cure rates and treatment completion rates compared to treatment delivered by health facilities.

LIFE Initiative increases role of USAID missions

The $100 million increase in FY 2000 U.S. support for sub-Saharan African countries and India — part of the five-year Leadership and Investment in Fighting an Epidemic (LIFE) Initiative — represents an important opportunity for USAID missions to address the deadly alliance of TB and HIV/AIDS. Working with national TB programs in target countries they can:

- determine the status of the twin epidemics and ensure that addressing the TB-HIV/AIDS link is part of the policy agendas of host governments, non-governmental organizations and USAID partners;
- assess whether DOTS therapy is offered only in pilot projects or is available nationally;
- identify areas of strength in which to assist national TB programs in expanding DOTS coverage or strengthening program components; and,
- help national TB programs establish more effective links to international HIV/AIDS programs and work with both to develop a care and support component that includes community-based treatment and prevention. ■

— Dr. Davis is an infectious disease adviser for the Africa Bureau.

By Senator Bill Frist (R-Tenn.)

Frist legislation seeks more funds to fight AIDS

Experience in Sudan clinic brought home HIV/AIDS threat

My first experience with the silent apocalypse of AIDS in Africa was during a medical mission into a war zone known more for its calculated starvation and loud and violent death from above than for staggering under the burden of disease.

In January of 1998, I flew to the town of Lui in southern Sudan, where I helped open a clinic and perform surgery by flashlight on everything from hernias to legs maimed by land mines. Upon arrival at the rudimentary hospital I was given only two tips intended to save my life: First, I had less than 90 seconds to get into the bomb shelters once we heard the drone of the engines of the government's bomber. (That hospital has since been bombed four times by the government.) Second, a stern warning to "double up" on latex gloves while working with wounded patients because of the chance of contracting HIV. Both made a deep impression and have guided me as Chairman of the Senate Foreign Relations' Subcommittee on African Affairs.

The cost in human life and productivity, as well as the potential societal and economic disruptions from AIDS assure us of one distinct possibility: All goals of the United States in Africa – goals we share with Africa — will be seriously compromised, if not completely undermined, by AIDS. Growing trade, better education and health, stronger democracies, efforts toward peace — all will be undermined by a disease that is

Sen. Frist's proposed legislation focuses on both prevention of AIDS and an eventual cure.

positioned to sap life from the most promising and productive generations. That is to say, in very short order, AIDS will become the single greatest policy challenge for the United States in Africa, and for Africans themselves, of course, driving all other policy considerations. It has the same potential in other parts of the world – it is not solely an African disease.

Two characteristics of this pandemic which distinguish it from the other great killers on the continent have shaped the Senate's recent initiative to support the efforts to combat HIV/AIDS worldwide.

The first is the fact that AIDS affects the younger members of a community in their most productive years. It contorts and eventually turns on its head the already strained economic equation by effectively reversing the proportion of dependents to productive members of a family. In short, it has struck at the heart of the extended families, changing the breadwinners into burdens. That is to say nothing of the grief, personal loss and often shame associated with death from AIDS.

The second is that the estimated number of orphans caused by AIDS in Africa already exceeds 10 million, and is expected to approach 40 million in coming years. Many of those children will themselves be HIV-positive. The prospect of 40 million children without hope, health and often without any support whatsoever is as dangerous as it is tragic. These children are susceptible to substance abuse, prostitution, banditry — even child soldiery. Their plight will be an economic strain on weakening or completely broken economies, and an extremely volatile element in strained societies.

With the unanimous support of my colleagues on the Senate Foreign Relations Committee, I successfully passed a proposal which includes, among other critical provisions, support for USAID's and the World Bank's programs for combating AIDS. It would also fund critical research into the ultimate weapon in the fight against disease: a vaccine. The legislation focuses on both prevention and an eventual cure. It authorizes funding of up to $460 million next year alone – nearly double the President's request. Its prospects for becoming law are good.

Congress and the Administration must be mindful that the United States can be a great force for good in Africa and the world. However, our job is to determine how best to use our limited resources to maximize their potential for good on the African continent. These are life and death decisions which cannot be addressed simply by allocating more funds. How we direct or allocate those resources will significantly impact the situation.

Issues involving life and death decisions are extremely difficult. Now, those decisions affect the future of an entire continent. ■

"…AIDS will become the single greatest policy challenge for the United States in Africa, and for Africans themselves…driving all other policy considerations."

By Bette Cook

Congress gets President Clinton's $22.75 billion FY 2001 international affairs budget, USAID budget $7.5 billion

USAID's budget justification (formerly called the congressional presentation), requesting $7.5 billion for agency-managed programs, was sent to Congress in March. The agency's budget is part of the International Affairs (Function 150) account, for which President Clinton submitted the Fiscal Year (FY) 2001 federal budget request on Feb. 7.

The international affairs budget for FY 2001 represents an increase of about $2 billion over the FY 2000 appropriation enacted last fall. This is apart from the FY 2000 supplemental funding for the Wye Accord ($1.825 billion), which Congress has approved, and pending supplemental requests for Plan Colombia ($818 million), Kosovo and Southeastern Europe ($251 million) and debt restructuring ($210 million).

Testifying before the Senate Foreign Relations Committee Feb. 10 and before the House International Relations Committee on March 15 in support of the agency's programs and budget request, Administrator J. Brady Anderson said, "USAID's work in development assistance takes time. It is an incremental process that pays off for America and for the world. Foreign assistance is a national security priority. USAID is a smart investment and one of the most effective tools the U.S. government has in building the foundations for trade and markets, and the spread of democratic ideas."

Highlights of the agency's priorities in this year's budget include:

- For HIV/AIDS programs, $259 million from all sources (Child Survival and Disease Programs Fund, Economic Support Fund,

(continued on back cover)

USAID Budget ($000)

	FY 1998 Appropriation	FY 1999 Appropriation	FY 2000 Appropriation	FY 2001 Request
Foreign Operations Subcommittee				
Child Survival and Disease Programs Fund [1]	650,000	700,000	724,866	659,250
Less transfer to UNICEF	-100,000	-105,000	-110,000	—
Subtotal – Child Survival and Disease	*550,000*	*595,000*	*614,866*	*659,250*
Development Assistance [1]	1,210,634	1,225,000	1,210,334	948,822
Less transfers to Inter-American Foundation/ African Development Foundation .	-36,000	-31,000	-19,326	—
Subtotal – Development Assistance	*1,174,634*	*1,194,000*	*1,191,008*	*948,822*
Development Fund for Africa	[445,143]	[452,487]	[448,830]	532,928
Subtotal Sustainable Development	*1,724,634*	*1,789,000*	*1,805,874*	*2,141,000*
International Disaster Assistance	190,298	388,000	202,014	220,000
Development Credit Programs [by transfer]	—	—	—	[15,000]
Development Credit Authority	[7,500]	—	[3,000]	—
Other Credit Programs-subsidy costs	4,500	3,000	3,000	—
USAID Operating Expenses [2]	478,858	502,792	518,960	520,000
Development Credit Programs – Admin. Expenses	—	—	—	8,000
Other Credit Programs-Admin. Expenses	6,553	5,446	5,490	—
Kosovo/S.E.Europe Initiative Supplemental request for USAID Operating Expenses	—	—	22,000	—
Inspector General Operating Expenses	29,047	27,117	24,950	27,000
Foreign Service Disability & Retirement [mandatory]	[44,208]	[44,552]	[43,837]	[44,489]
Economic Support Fund & International Fund for Ireland	2,419,928	2,594,100	2,792,187	2,313,000
Central America/Caribbean Disaster Recovery Fund	—	613,500	—	—
Assistance to the Independent States [1]	770,798	847,000	835,812	830,000
Support for East European and the Baltics,SEED (Support for East European Democracy Act) [1]	485,276	550,000	532,970	610,000
Kosovo/Southeast Europe Initiative-suppl. request-SEED	—	—	195,000	—
Plan Colombia request-USAID-managed portion [3]	—	—	[127,500]	[90,000]
Foreign Operations Subtotal	*6,109,892*	*7,319,955*	*6,938,257*	*6,669,000*
Agriculture Subcommittee				
P.L. 480 Food For Peace Title II	837,000	986,200	800,000	837,000
P.L. 480 Food For Peace Title III	30,000	25,000	—	—
USAID Total:	6,976,892	8,331,155	7,738,257	7,506,000

1 To be consistent with the FY 2001 request, the FY 1998 through FY 2000 levels exclude congressionally mandated Development Assistance transfers to the African Development Foundation and the Inter-American Foundation and congressionally mandated Child Survival and Disease transfers to UNICEF, but include funds ultimately transferred from SEED and FREEDOM Support Act funds to other agencies.
2 FY 1998 through FY 2000 levels include congressionally authorized transfers to Operating Expenses from other USAID program accounts but exclude local currency trust funds and prior year funds.
3 Plan Colombia request presented parenthetically because it is requested by the Department of State; the amount shown is the USAID-managed portion.

WHERE

Moved On

Angola *Luanda*
Director Keith Simmons
Benin *Cotonou*
Director Thomas E. Park
Democratic Republic of the Congo *Kinshasa*
Director Janet Schulman (Acting)
Eritrea *Asmara*
Director William J. Garvelink
Ethiopia *Addis Ababa*
Director Douglas Sheldon
Dep. Director David Eckerson
Ghana *Accra*
Director Frank J. Young
Dep. Director Jay Knott
Guinea *Conakry*
Director Harry Birnholz
Guinea-Bissau *Bissau*
Director Donald Clark (Acting)
Kenya *Nairobi*
Director Jonathan Conly
Liberia *Monrovia*
Director Rudolph Thomas
Madagascar *Antananarivo*
Director Karen M. Poe
Malawi *Lilongwe*
Director Kiertisak Toh
Mali *Bamako*
Director James Hradsky
Dep. Director Paul Tuebner
Mozambique *Maputo*
Director Cynthia Rozell
Dep. Director David Hess
Namibia *Windhoek*
Director Carole Scherrer-Palma
Nigeria *Lagos*
Director Thomas Hobgood
Rwanda *Kigali*
Director Richard Goldman
Senegal *Dakar*
Director Donald Clark
Dep. Director Allan E. Reed
South Africa *Pretoria*
Director William Stacey Rhodes
Dep. Director Eilene B. Oldwine
Tanzania *Dar es Salaam*
Director Lucretia Taylor
The Sudan *Khartoum*
Sudan Field Office Coordinator
Larry Meserve
(Headquartered in Nairobi, Kenya)
Uganda *Kampala*
Director Dawn Liberi
Dep. Director Patrick Fleuret
Zambia *Lusaka*
Director Walter North
Zimbabwe *Harare*
Director Rose Marie Depp

Regional Economic Development Services Offices

East & Southern Africa (REDSO/ESA)
Kenya *Nairobi*
Director Donald R. Mackenzie
Dep. Director Steven G. Wisecarver
Regional Center for Southern Africa (RCSA)
Botswana *Gaborone*
Director Edward J. Spriggs
Dep. Director Anthony Vance

Asia

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Director Gordon H. West
Dep. Director Anne Aarnes
Cambodia *Phnom Penh*
Director Willard J. Pearson,Jr.
India *New Delhi*
Director Linda E. Morse
Dep. Director James Bever
Indonesia *Jakarta*
Director Terry (Desaix) Myers
Dep. Director Sharon Lee Cromer
Nepal *Kathmandu*
Director Joanne Hale
The Philippines *Manila*
Director Patricia Buckles
Dep. Director (Vacant)
Sri Lanka *Colombo*
Director Lisa Chiles
USAID Offices
Mongolia *Ulaanbaatar*
Director Edward W. Birgells

Near East

Egypt *Cairo*
Director Richard M. Brown
Dep. Director Toni Christiansen-Wagner
Jordan *Amman*
Director Lewis W. Lucke
Morocco *Rabat*
Director James Bednar
West Bank/Gaza
Director Larry Garber
Dep. Director William P. Hammink

USAID Offices
Lebanon *Beirut*
Director James (Spike) Stephenson

Europe and Eurasia

Bosnia *Sarajevo*
Director Craig Buck
Albania *Tirana*
Director Howard Sumka
Bulgaria *Sofia*
Director John Grant
Croatia *Zagreb*
Director Charles R. Aanenson
Caucasus *Tbilisi*
Director Michael Farbman
Dep. Director P.E. Balakrishnan
Kosovo *Pristina*
Director Craig Buck
Lithuania *Vilnius*
Director (Vacant)
Macedonia Skopje
Director Stephen Haynes
Poland *Warsaw*
Director William M. Frej
Romania *Bucharest*
Director Denny Robertson
Serbia *(Belgrade)* Federal Republic of Yugoslavia
Director Richard J. Hough
Slovakia *Bratislava*
Director Paula Goddard
Regional Services Center (RSC/E&E)
Budapest *Hungary*
Director Patricia Lerner
Russia *Moscow*
Director Carol Peasley
Dep. Director Mark Ward
Ukraine *Kiev*
Director Christopher Crowley
Dep. Director Richard Goughnour
Regional Mission for the Caucasus
Armenia *Yerevan*
Director Diana Tsitsos
Dep. Director Jatinder Cheema
Regional Mission for Central Asia Republic
Kazakhstan *Almaty*
Director Glen Anders
Dep. Director Vicki Moore

Latin America and the Caribbean

Bolivia *La Paz*
Director Liliana Ayalde
Dep. Director Wayne Nilsestuen
Brazil *Brasilia*
Director Janice Weber
Colombia *Bogota*

Robinson, Natasha
Wilson, Ernest

Promoted

Atherton, Joan
Austin, Paul
Bowen, Patricia
Braxton, Annette
Broadnax, Tanya

Allaire MacDonald, Julie
Bambara, Alicia
Crawford, A. Lindsey
Foltz, Jennifer

Obituaries

R. James Falconer Jr., 55, died Jan. 28 of an abdominal hemorrhage at his home in Arlington, Va. Falconer joined USAID in 1987 and was a personnel officer in the Foreign Service Personnel Division before joining the Bureau for Humanitarian Response, where he served as an administrative officer until his death. Falconer was in the first group of Peace Corps volunteers sent to Guyana in 1965 and was a special assistant to the Peace Corps director and other officials until the late 1970s.

Ralph Dean Fry, 87, died Jan. 3 at Newton Memorial Hospital in Winfied, Kan. Fry joined USAID's predecessor agency in 1953 as a Foreign Service officer. He worked in Tripoli, Libya, as a drilling superintendent and supervised the teaching of Libyans in water exploration, development and purification. Fry also served in Egypt, Laos and Vietnam. In Egypt, he headed a drilling operation that uncovered water 3,000 feet beneath the Sahara Desert. Fry retired from USAID in 1975.

Congress gets USAID budget: $7.5 billion

(continued from page 12)
FREEDOM Support Act fund, and P.L. 480 resources), up from $200 million in FY 2000. USAID joins other agencies in supporting President Clinton's new Leadership and Investment in Fighting the Epidemic (LIFE) Initiative first funded in FY 2000.

- A population program funding level of $542 million from all accounts, bringing agency funding for this activity back to the FY 1995 funding level.
- Support for two new presidential environmental initiatives – Clean Energy for the 21st Century ($30 million, part of a $100 million interagency program) and Tropical Forest and Biodiversity ($33 million). The latter initiative is part of the new "Greening the Globe" initiative President Clinton announced in the FY 2001 budget.
- An increase of $18 million in Disaster Assistance funds, for a total request of $220 million.
- A separate Development Fund for Africa, totaling $533 million, is requested, compared to $449 million in Development Assistance budgeted for Africa in FY 2000. This excludes funds budgeted for Africa in the Child Survival and Disease Programs Fund.
- An increase in funding to $136.5 million to support Indonesia's economic and democratic transition.
- An increase in funding to $96 million from all sources (Development Assistance, Child Survival and Disease Programs Fund, Economic Support Funds and recoveries) for Nigeria, which is undergoing a profound transformation to democracy.
- A two-year $1.3 billion request, in addition to the $300 million for current programs, for Plan Colombia, a comprehensive counter-narcotics strategy for Colombia and other Andean countries. USAID will administer a portion of these funds (see estimates in chart). ■

"USAID is a smart investment and one of the most effective tools the U.S. government has in building the foundations for trade and markets, and the spread of democratic ideas."

–Administrator J. Brady Anderson

— **Cook** is a legislative program specialist in the Bureau for Legislative and Public Affairs.